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"Over 29 Years of Excellence"

PENNSPORT PHYSICAL THERAPY

PERSONAL HISTORY

NAME:______________________ DATE OF BIRTH:__________ AGE:_____

ADDRESS:____

HOME PHONE #:________________ CELL PHONE#:________________

EMAIL ADDRESS:____

SOCIAL SECURITY #:______________________

EMERGENCY NAME & PHONE #:______________________________

EMPLOYMENT INFORMATION

EMPLOYER:____

JOB TITLE:____

ADDRESS:____

PHONE #:____

ARE YOU PRESENTLY WORKING (PLEASE CIRCLE): YES OR NO

INSURANCE INFORMATION

PRIMARY INSURANCE:________________ PHONE #:________________
ID/CLAIM #:________________ GROUP #:________________
POLICY HOLDER NAME:________________ DOB (IF OTHER THAN PATIENT)__________
BENEFITS THROUGH (PLEASE CIRCLE ONE): EMPLOYER UNION MARKETPLACE OTHER

SECONDARY INSURANCE:________________ PHONE #:________________
ID/CLAIM #:________________ GROUP #:________________
POLICY HOLDER NAME:________________ DOB (IF OTHER THAN PATIENT)__________
BENEFITS THROUGH (PLEASE CIRCLE ONE): EMPLOYER UNION MARKETPLACE OTHER

SPOUSE'S INFORMATION

NAME:________________ DATE OF BIRTH __________

SOCIAL SECURITY #:________________

SPOUSE'S INSURANCE____

HOW YOU WERE REFERRED TO PENNSPORT PT

PHYSICIAN_______ RELATIVE_____ FRIEND______

ATTORNEY_______ TV_______ PHONE BOOK_____ OTHER________________

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MEDICAL HISTORY

PATIENT NAME:__________________ DOB:________________

HEIGHT:______________ WEIGHT:____________

PRIMARY CARE PHYSICIAN'S NAME:______________________ NEXT DR. APPT:__________

INJURY INFORMATION

REFERRING PHYSICIAN NAME & PHONE #:____

HOW DID INJURY OCCUR (PLEASE CIRCLE):

AUTO ACCIDENT AT WORK AT HOME OTHER

DATE OF INJURY:____

DESCRIBE BRIEFLY:

____

____

WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICUTLY WITH:

1.____
2.____
3.____

HAVE YOU HAD PHYSICAL THERAPY FOR THIS CONDITION IN THE PAST? (CIRCLE ONE) YES/NO
IF YES, WHEN DID YOU RECEIVE THE TREATMENT AND WHAT WERE THE RESULTS?

____

____

HAVE YOU HAD PRIOR PHYSICAL THERAPY THIS CALENDAR YEAR? (CIRCLE ONE) YES/NO
IF YES, WHERE WAS IT RECEIVED (CIRCLE ONE): HOSPITAL/OUTPATIENT CENTER/HOME HEALTH
FOR HOW LONG:____

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS (CHECK ALL THAT APPLY):

__ANEMIA	__DEPRESSION	__HEPATITIS/HIV	__CURRENTLY PREGNANT
__ASTHMA	__DIZZINESS	__FAINTING	__KIDNEY PROBLEMS
__SEIZURES	__CANCER	__FRACTURES	__HIGH BLOOD PRESSURE

__HEART ATTACK __PACEMAKER __HEADACHES __LOW BLOOD PRESSURE

__HEART MURMUR __HEART DISEASE __ATRIAL FIBRILLATION __DIABETES (__TYPE 1 OR __TYPE 2)

__METAL IMPLANTS __STROKE __THYROID PROBLEM __OSTEOPEROSIS

__GI PROBLEMS __LUNG DISEASE __LIVER DISEASE __CIRCULATORY PROBLEMS

__BOWEL/BLADDER CHANGES __RESPIRATORY PROBLEMS

OTHER MEDICAL PROBLEMS/SURGERIES:

____

____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING WITH DOSAGE:

____

____

LIST ANY MEDICATIONS YOU ARE ALLERGIC TO:

____

____

DO YOU REACT TO LATEX OR RUBBER (GLOVES, BALLOONS, ETC) WITH A RASH, WHEEZING, ETC? (PLEASE CIRCLE ONE) YES OR NO

______________________________ ______________________

SIGNATURE OF PATIENT/PARENT OR GUARDIAN DATE

____

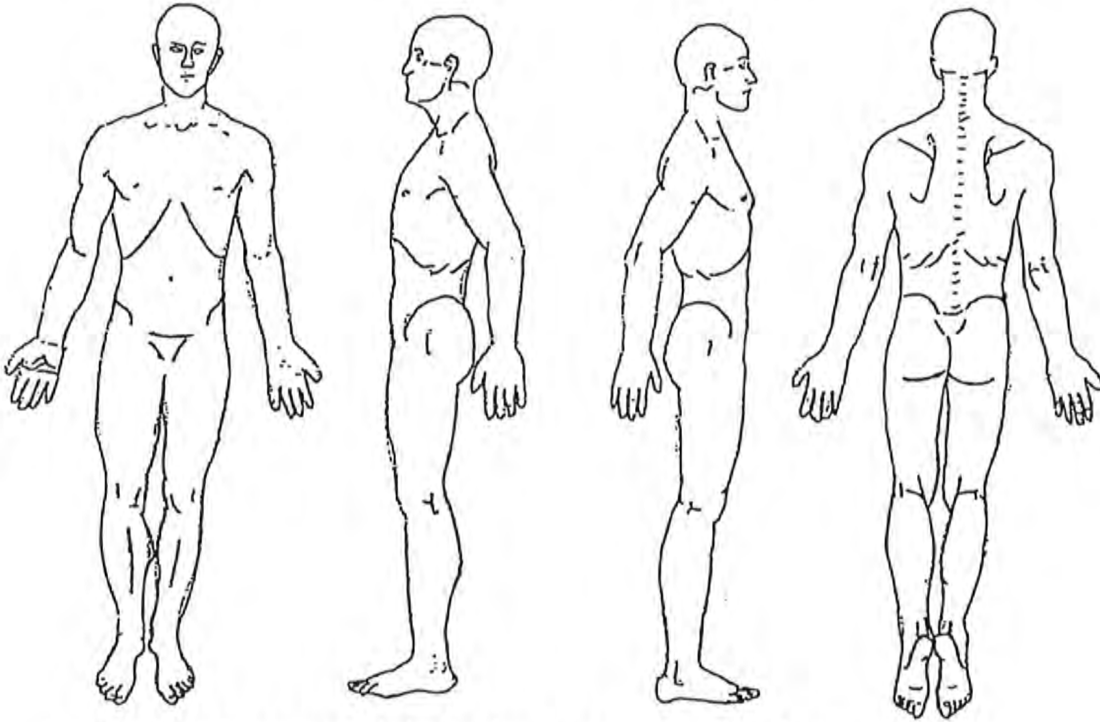
NAME (PLEASE PRINT)

PAIN ASSESSMENT FORM

Name: ______________________________ Date: ______________

1. ☐ Initial Visit ☐ Follow-up Visit

2. Please mark or shade the areas of your body where you feel pain on the diagrams below.



3. Next to each area marked above, please note the intensity of pain

No Pain	Minimal	Tolerable, but Hinders activity	High – 50% of activities impaired	Extreme – most activities impaired	Unbearable
0	1 2	3 4	5 6	7 8	9 10

Reviewed: ______________________

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PENNSPORT PHYSICAL THERAPY

Statement of Patient Financial Responsibility and Patient Policies

We, the staff of Pennsport Physical Therapy, thank you for choosing us as your physical therapy provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest quality care and building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities; please feel free to contact our office at 215-467-4431.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Please understand that payment for services is an important part of the provider/patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

We accept payments for your convenience such as cash or check. A $35.00 service fee will be charged for all returned checks.

We realize that temporary financial problems may affect timely payment of your account. If this should occur please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

Interest
Interest will incur at 6% if a balance remains unpaid after 60 days.

Insurance
Please remember that your insurance is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from the insurance carrier.

We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claim.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization, and referral information and to notify our office of any information changes when they occur. Even a pre-authorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co- payments, co-insurance, and deductibles, as outlined by your insurance carrier.

Please also note that it is your responsibility to have approval for physical therapy from your insurance company prior to your initial physical therapy visit if one is required. If the insurance company denies payment for physical therapy on the basis a referral was not obtained or you have exceeded the number of approved therapy visits, you are personally responsible for payment of services rendered at Pennsport Physical Therapy. Furthermore, if you elect to continue services past your coverage/policy period, you will be responsible for the remaining balance on your account.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of- network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

Medicare

If you have Medicare as your primary insurance, Medicare will cover therapy services at 80% of all approved charges. You are financially responsible for the remaining 20% along with the annual deductible (if it has not already been met). The remaining 20% may be covered if you have supplement/secondary insurance. Outpatient physical therapy has an annual cap of $1,960.00 which is combine with speech therapy.

Miscellaneous Forms, Additional Information and Authorizations

We will provide all necessary information to have your benefits released. However if it becomes necessary to submit redundant or unnecessary information for the completion of the claim forms for school, sports, or extra-curricular activities; there will be an administrative fee, not to exceed $35.00, for the additional information.

Missed Appointments

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us 24 hours in advance, a missed appointment fee will apply. The no show/cancellation fee is $30.00 per missed appointment. This fee is not covered by insurance. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients. Your physician will be notified of the fact that services have been discontinued due to non-compliance with the prescribed rehabilitation order.

Records Fees

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines and exceptions to ensure compliance to patient rights. However, providers also have the right to be compensated for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files and or summaries.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

Supplies

Patients are financially responsible for any and all supplies that are given to me during the course of my treatment. Payment will be due on the day the supply was received.

Timeliness of Appointments

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy. I agree to assign insurance benefits to Pennsport Physical Therapy whenever applicable. I also agree, in addition to the amount owed, I am responsible for all costs of collections if such action becomes necessary.

____________________________________ _________________

Signature of Insured or Authorized Representative Date

PENNSPORT PHYSICAL THERAPY
2101 S. Columbus Boulevard
Philadelphia, PA 19148
Phone: (215)467-4431 Fax: (215)467-8879

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Pennsport Physical Therapy to furnish medical care and treatment to ________________________, which is considered necessary and proper in the diagnosing and treating of my (their) physical condition.

Signature ____________________________ Date ______________________

(Patient/Guardian)

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I acknowledge receipt of and agree to Pennsport Physical Therapy's Notice of Privacy Practices with respect to protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

________________________ ________________________

Signature Date

I, ____________________, give permission to Pennsport Physical Therapy to use/disclose my protected health information (medical/billing records) to:

____

Name & Relationship to Patient

____

Name & Relationship to Patient

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may revoke this authorization in writing at any time by sending written notification to Pennsport Physical Therapy at 2101 S. Columbus Blvd. Philadelphia, PA 19148. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

________________________ ________________________

Signature of Patient/Guardian Date

____

Printed Name of Patient/Guardian

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NOTICE OF PRIVACY PRACTICES

This notice describes the privacy practices of **Pennsport Physical Therapy.** We are required by law to maintain the privacy of medical and health information about you and to provide you with this notice of our legal duties and privacy practices with respect to "Protected Health Information". The **Health Insurance Portability & Accountability Act of 1996 (HIPAA)** requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically or paper to be kept confidential. This federal law gave you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. The law allows us to provide you with our practice policy in order that you may be aware of how your medical records are handled in our office.

According to the law, we are permitted to use and disclose your health care records for the following purposes:

- **Treatment**: We will use and disclose your personal health information to provide proper treatment and other services to you to help diagnose and treat your injuries or illnesses. We may also use your personal information and health information by sharing with other providers who are involved with your treatment and care.

- **Payment:** We may use your personal health information to obtain payment for services that have been provided. We may also share this information with other providers who are also providing treatment for the illness and injuries which you are under our care.

- **Health Care Operations:** This is the administration portion of the practice. We may disclose your private health care information to other health care providers or companies in order to obtain payment or approval of treatment when necessary. We may use your information to make needed appointments, or other health related services.

- We may also release your protected health information if requested by law enforcement, public health authorities that are authorized by law to collect information, response to a court order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute. We will notify by copy either you or your legal representative if records are released.

- In addition to the use of your health information for treatment, payment and other healthcare operations, you may give us written authorization to use your information or to disclose it to anyone for any purpose. You have the right to revoke this authorization in writing at any time. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

If you have any questions regarding this notice of our policy or regarding your "Protected Health Information", please feel free to call our office and ask to speak with our office manager.

September 2016